Senate

General Assembly

File No. 75

February Session, 2014

Senate Bill No. 176

Senate, March 24, 2014

The Committee on Aging reported through SEN. AYALA, A. of the 23rd Dist., Chairperson of the Committee on the part of the Senate, that the bill ought to pass.

AN ACT CONCERNING THE PURCHASE OF MEDICARE SUPPLEMENT POLICIES BY QUALIFIED MEDICARE BENEFICIARIES.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Section 38a-495c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2014*):

(a) Each insurance company, fraternal benefit society, hospital service corporation, medical service corporation, health care center or other entity in this state that delivers, issues for delivery, continues or renews any Medicare supplement insurance policies or certificates shall base the premium rates charged on a community rate. Such rate shall not be based on age, gender, previous claims history or the medical condition of the person covered by such policy or certificate. Except as provided in subsection (c) of this section, coverage shall not be denied on the basis of age, gender, previous claim history or the medical condition of the person covered by such policy or certificate.

(b) Nothing in this section shall prohibit an insurance company, fraternal benefit society, hospital service corporation, medical service corporation, health care center or other entity in this state issuing Medicare supplement insurance policies or certificates from using its usual and customary underwriting procedures, provided no such company, society, corporation, center or other entity shall issue a Medicare supplement policy or certificate based on the age, gender, previous claims history or the medical condition of the applicant.

(c) Nothing in this section shall prohibit an insurance company, fraternal benefit society, hospital service corporation, medical service corporation, health care center or other entity in this state when granting coverage under a Medicare supplement policy or certificate from excluding benefits for losses incurred within six months from the effective date of coverage based on a preexisting condition, in accordance with section 38a-495a and the regulations adopted pursuant to section 38a-495a.

(d) Each insurance company, fraternal benefit society, hospital service corporation, medical service corporation, health care center or other entity in the state issuing Medicare supplement policies or certificates for plan "A", "B" or "C", or any combination thereof, to persons eligible for Medicare by reason of age, shall offer for sale the same such policies or certificates to persons eligible for Medicare by reason of disability.

(e) To the extent permissible by federal law, each insurance company, fraternal benefit society, hospital service corporation, medical service corporation, health care center or other entity in the state issuing Medicare supplement policies or certificates for plan "A", "B" or "C", or any combination thereof, may deliver or issue for delivery such policy to a qualified Medicare beneficiary, as defined in 42 USC 1396d(p).

[(e)**]** (f) Each insurance company, fraternal benefit society, hospital service corporation, medical service corporation, health care center or other entity in the state issuing Medicare supplement policies or

certificates shall make all necessary arrangements with the Medicare Part B carrier and all Medicare Part A intermediaries to allow for the forwarding, to the issuing entity, of all Medicare claims containing the name of the entity issuing a Medicare supplement policy or certificate and the identification number of an insured. The entity issuing the Medicare supplement policy or certificate shall process all benefits available to an insured from a Medicare claim so forwarded, without requiring any additional action on the part of the insured.

[(f)**]** (g) The Insurance Commissioner may adopt regulations, in accordance with chapter 54, to implement this section.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*July 1, 2014*	38a-495c

AGE *Joint Favorable*

OFA Fiscal Note

State Impact: None

Municipal Impact: None

Explanation

The bill allows qualified Medicare beneficiaries to purchase supplemental Medicare policies. As this concerns interactions between private entities, there is no state or municipal fiscal impact.

The Out Years

State Impact: None

Municipal Impact: None

OLR Bill Analysis

SB 176

AN ACT CONCERNING THE PURCHASE OF MEDICARE SUPPLEMENT POLICIES BY QUALIFIED MEDICARE BENEFICIARIES.

SUMMARY:

This bill allows certain insurers and other specified private entities to deliver or issue policies supplementing Medicare health insurance to low-income Medicare recipients who are already receiving state assistance to help pay Medicare deductibles, coinsurance, and copays (i.e., Qualified Medicare Beneficiaries (QMBs)). An entity may only issue or deliver policies that supplement Medicare plans A, B, or C, or any combination of these plans. This option is available to insurers, fraternal benefit societies, hospitals, medical service corporations, and HMOs only to the extent federal law allows. But federal law specifies conditions that appear to prohibit these entities from selling supplemental policies to QMBs in Connecticut (see COMMENT).

EFFECTIVE DATE: July 1, 2014

BACKGROUND

Medicare Supplemental Policies

Federal law standardized Medicare supplement policies into 10 benefit policies designated A, B, C, D, F, G, K, L, M, and N (policies E, H, I, and J are no longer sold). Policy A contains the core benefits, while the other nine policies also provide one or more additional benefits. For example, policy B also covers Part A deductibles and policy C covers Part A and B deductibles, skilled nursing facility care coinsurance, and foreign travel emergency benefits.

QMBs

QMB is one of three designations under the state Medicare Savings Program (MSP) designed to help low-income individuals pay for Medicare Part B premiums and other services. Under the QMB program, the state's Medicaid program pays the Medicare beneficiaries' Part A and B premiums and certain other cost-sharing (including co-pays and deductibles on Medicare-covered services) as a way to reduce the likelihood that these individuals will require full Medicaid coverage. The state pays the cost-sharing and receives a partial reimbursement from the federal government. The state pays only when the beneficiary's medical provider accepts both Medicare and Medicaid.

The other two MSP designations are Special Low Income Medicare Beneficiary (SLMB) and Additional Low Income Medicare Beneficiary (ALMB). Current eligible monthly income limits range from approximately $2,021 for an individual enrolled in the QMB program ($2,700 for a couple) to $2,356 for an individual enrolled in the ALMB program ($3,180 for a couple).

COMMENT

Federal Prohibition

Federal law allows an insurer to sell or issue supplemental insurance to a person eligible for Medicaid Part A or enrolled in Medicare Part B only if that person provides a statement outlining their health insurance policies and any Medicare benefits to which they are entitled. If the person is Medicaid-eligible, the insurer may sell or issue supplemental insurance only if that eligibility is limited to payments of Part B premiums. In Connecticut, QMB recipients are entitled to assistance for copays and deductibles in addition to Part B premium payments. As a result, selling or issuing supplemental policies to these recipients appears to violate federal law.

COMMITTEE ACTION

Aging Committee

Joint Favorable

Yea 12 Nay 0 (03/11/2014)